DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

AUTHORIZATION FOR REALEASE OF MEDICAL INFORMATION

TO: _____

_____

_____

I hereby request and authorize you to release medical information concerning me, with particular reference to:

_____

_____

_____

_____

_____

Please release and send information to:

Medical Officer in Charge
Occupational Medical Service
Attention: _____
National Institutes of Health
Building 10, Room 6C-306
Bethesda, MD 20892

Signed: _____
Address: _____
_____
_____

Witnessed: _____ Date: _____

Please print patient name and identification number:

_____ _____